DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/IDENTIFICATION NUMBER 395400			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00_ B. WING:		(X3) DATE SURVEY COMPLETED: 04/03/2023					
NAME OF PROVIDER OR SUPPLIER: SUSQUEHANNA HEALTH AND WELLNESS CENTER			745 CHIQUES	STREET ADDRESS, CITY, STATE, ZIP CODE: 745 CHIQUES HILL ROAD COLUMBIA, PA 17512						
STATE LICENS	E NUMBER: 084802									
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	CORRECTIVE ACTION SHO	OVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIATE				
F 0000	Findings of an Abbreviated Complaint Surcompleted on April 3, 2023, at Susquehann and Wellness Center, identified a deficient related to the reported complaint allegation the requirements of 42 CFR Part 483, Subp Requirements for Long Term Care Facilitie 28 PA Code, Commonwealth of Pennsylva Term Care Licensure Regulations as they rethe Health portion of the survey process.		na Health practice, us, under part B es and the unia Long	F 0000						

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TITLE:

(X6) DATE:

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
395400				00	04/03/2023		
				S HILL ROA		OULD BE	(X5) COMPLETE DATE
P 2020	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEF MUST BE PRECEEDED BY FULL REGULATORY OR IDENTIFYING INFORMATION) § 211.12(i) Nursing services. (i) A minimum number of general nursing care I shall be provided for each 24-hour period. The total number of hours of general nursing care provided in 24-hour period shall, when totaled for the entire facil a minimum of 2.7 hours of direct resident care for earesident. This REGULATION is not met as evidenced by:		l n each ility, be ach	P 2020	The facility will provide app direct care staffing of 2.7 NF meet the needs of the resider Facility residents have the pt to be affected by this practic. The Administrator, Nursing Management Team and Nurse Scheduler will review the nuschedule and deployment shadily to ensure RN coverage. The Administrator/designee present the results of these at the Quality Assurance and Performance Committee mofurther review and recomme	ropriate PPD to its. Intential ite. Ising irsing itests Item will intential to the property of the property	Completion Date: 04/21/2023 Status: APPROVED Date: 04/18/2023
LABORATORY	DIRECTOR'S OR PROVIDER/SUPPLI	ER REPRESENTATIVE'S SIGN.	ATURE		TITLE:	(X6) DATE:	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
395400					04/03/2023		
NAME OF PROVIDER OR SUPPLIER: SUSQUEHANNA HEALTH AND WELLNESS CENTER STATE LICENSE NUMBER: 084802			STREET ADDRESS, 745 CHIQUES COLUMBIA,	HILL ROA			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DE PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF TAG IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	(X5) COMPLETE DATE	
P 2020	Continued from page 1 Based upon review of s		P 2020				
	interviews with staff, it facility failed to ensure state required minimum resident care per person out of three weeks revi	e above the					
	Findings include: Review of staffing record through March 28, 202 not meet staffing levels March 10, 2023, 2.49 ppd; March 17,2023, 2 2.37 ppd; and March 2	ity did ntes: 3, 2.61 2023,					
	confirmed that the faci hours, for these dates. The facility failed to er the minimum State reg	nsure that staffing le	vels met				

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Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 395400			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 04/03/2023		
NAME OF PROVIDER OR SUPPLIER: SUSQUEHANNA HEALTH AND WELLNESS CENTER STATE LICENSE NUMBER: 084802			STREET ADDRESS, CITY, STATE, ZIP CODE: 745 CHIQUES HILL ROAD COLUMBIA, PA 17512				
(X4) ID PREFIX TAG	EFIX MUST BE PRECEEDED BY FULL REGULATORY O			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
P 2020	Continued from page 2 days in March 2023.			P 2020			

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Certified End Page

SUSQUEHANNA HEALTH AND WELLNESS CENTER

STATE LICENSE NUMBER: 084802 SURVEY EXIT DATE: 04/03/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY